Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: VISTA HOSPITAL OF DALLAS 4301 VISTA ROAD PASADENA TX 77504	MFDR Tracking #: M4-09-7817-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO REP. BOX #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…With regard to the charges at issue in this dispute, there is no evidence presented by the Carrier that the prices billed were not Provider's usual and customary charges (which the Provider must bill under Division rules) or that the final price was not fair and reasonable. Therefore, the Carrier is required to reimburse Provider $1,821.88 pursuant to the Outpatient Fee Guideline, which will result in fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of $647.21. Therefore, the Carrier is required to reimburse Provider in the additional amount of $1,174.67, plus any and all applicable interest…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill
3. EOBs
4. Medical Reports
5. Total Amount Sought $1,174.67

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Insurance Carrier did not submit a response to the dispute as reflected in the dispute file and MDRIS operating system.

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
04/25/2008	HCPCS Codes J3490, A4649 CPT Codes 85025, 80053,84703,Q9966, Q0092, 62264, 99144, 99234, 20550	N/A	$1,174.67	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 07/02/2008:
   - CAC-18 – Duplicate Claim Service and
   - 224 – Duplicate Charge.
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated;
   - 284 – No allowance was recommended as this procedure has a Medicare status of "B" (Bundled);
   - 370 – This Hospital Outpatient allowance was calculated according to the APC rate plus a markup;
   - 494 – Hospital Outpatient allowance was calculated to Medicare's methodology plus a markup per the Texas OMFS;
   - 618 – The value of this procedure is included in the value of another procedure performed on this date; and
   - 930 – Pre-Authorization required, reimbursement denied.

   Explanation of benefits with the listed date of audit 07/09/2008:
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment;
   - CAC-197 – Precertification/Authorization/Notification absent;
   - 370 – This Hospital Outpatient allowance was calculated according to the APC rate plus a markup;
   - 494 – Hospital Outpatient allowance was calculated to Medicare's methodology plus a markup per the Texas Fee Schedule;
   - 618 – The value of this procedure is included in the value of another procedure performed on this date;
   - 891 – The insurance company is reducing or denying payment after reconsideration; and
   - 930 – Pre-authorization required. Reimbursement denied.

2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

3. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

(3) Separate reimbursement for implantables was *NOT* requested by the requestor.

6. HCPCS codes J3490, billed under Revenue code 250; A4649, billed under Revenue code 270; A4649, billed under Revenue code 272; CPT codes Q9966 and Q0092, billed under Revenue code 320; and 99144, billed under Revenue code 370 are considered Status N codes. Status N codes are considered services or procedures included in the APC rate, but not paid separately. As a result, the amount ordered is $0.00.
7. CPT Code 85025, billed under Revenue Code 300 is considered a Status A code. Status A codes are paid under a fee schedule or with a prospectively pre-determined rate. The Requestor billed $134.75; the Medicare fee is $10.86 multiplied by 125% equals $13.58. According to the Explanation of Benefits dated 07/09/2008 the Requestor was reimbursed $13.68. As a result, the amount ordered is $0.00.
8. CPT Code 80053, billed under Revenue Code 300 is considered a Status A code. Status A codes are paid under a fee schedule or with a prospectively pre-determined rate. The Requestor billed $132.50; the Medicare fee is $14.77 multiplied by 125% equals $18.46. According to the Explanation of Benefits dated 07/09/2008 the Requestor was reimbursed $18.46. As a result, the amount ordered is $0.00.
9. CPT Code 84703, billed under Revenue Code 300 is considered a Status A code. Status A codes are paid under a fee schedule or with a prospectively pre-determined rate. The Requestor billed $69.58; the Medicare fee is $10.49 multiplied by 125% equals $13.11. According to the Explanation of Benefits dated 07/09/2008 the Requestor was reimbursed $13.11. As a result, the amount ordered is $0.00.
10. CPT Code 62264, billed under Revenue Code 360 is considered a Status T Code. Status T codes are considered to be outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. The Respondent has denied this code for lack of preauthorization. The preauthorization approval dated April 22, 2008 shows that the Respondent preauthorized 1 unit for Rt ESI L4-5 and B SI inj 62311 as being medically necessary. The Requestor has not submitted documentation to support this code was part of the preauthorization request. As a result, the amount ordered is $0.00.
11. CPT Code 99234, billed under Revenue 760 is considered a Status B Code. Status B codes are not recognized by OPPS on bill type 12X, 13X or 14X; an alternate CPT/HCPCS code may be available. As a result, the amount ordered is $0.00.
12. CPT Code 20550, billed under Revenue Code 360 is considered a Status T code. Status T codes are considered to be outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. The maximum allowable reimbursement for this particular code is $29.57 x 200% = $59.14; the Requestor billed $1995.00 and was reimbursed $291.90. As a result, the amount ordered is $0.00.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.

		May 10, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.